

S. No. 2  
OM-5-43  
ev. 5-17-39  
I X36671

**FILED** SEP 12 1945

Registration District No. 5572 Primary Registration District No. 5572

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Rural - Prairie - 4 mi. N. of Summit  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
2 mi North of Lee Summit  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days 7 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
 (c) City or town Rural Prairie  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2 mi North Lee Summit  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Vivian G. Butler  
 (b) If veteran, name war no  
 (c) Social Security No. 500-22-1713

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 28  
 year 1945 hour 2 minute 45 P.  
 21. I hereby certify that I attended the deceased from 8-28 1945 to 8-28 1945  
 that I last saw her alive on 8-28 and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Sam. D. Butler 6. (c) Age of husband or wife if alive 40 years  
 7. Birth date of deceased June 6 - 1902  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration 4 hrs  
 Due to Hypertension ?  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
43 2 15 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Sedalia Mo.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation House wife

11. Industry or business Home  
 12. Name Clarence Byard  
 13. Birthplace unknown 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name unknown  
 15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr Clarence Byard  
 (b) Address Blue Springs Mo  
 17. (a) Burial (b) Date thereof 8-30-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation floral Hills - Mo

18. (a) Signature of funeral director W.B. Langford  
 (b) Address Lee's Summit Mo  
 19. (a) Aug 29, 1945 (b) F.M. Schick Reg. E.M.  
(Date received local registrar) (Registrar's signature)

PHYSICIAN  
 Major findings: (none)  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature (Signature) (M. D. or other) Med  
 Address Lee's Summit Mo Date signed 8-29-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

18  
0  
0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *W. B. Langford*

Licensed Embalmer No. *0833*

P. O. Address *Lees Summit, Va.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.